California Health Care Foundation

November 2018

HOW TO PAY FOR IT

Financing Community Health Workers in Transitions Clinics

The Transitions Clinic model is an evidence-based program designed to serve people with chronic diseases who have recently been released from incarceration. Operated by health centers located in communities with high rates of incarceration, Transitions Clinic Network (TCN) programs assist people in this vulnerable population with reintegration into their neighborhoods and lives. TCN sites have served thousands of patients in California and other states. TCN provides training, coaching, and networking opportunities to help clinics launch and grow these programs.

Founded on the idea that people with lived experience are best able to support people returning to their communities, each clinic that adopts the TCN model employs a community health worker (CHW) with a history of incarceration as a vital member of its clinical team. CHWs meet with all patients one-on-one, connecting them with health and social services through outreach, assessment, education, counseling, follow-up, and advocacy. Working both inside and outside the clinic, CHWs act as liaisons that help ensure that clients receive culturally relevant health services. They build a unique trust with clients the sees them using primary care more, using emergency departments less, and being hospitalized less often. Training for CHWs in the TCN can be provided in a number of ways, including TCN's specialized online training or an in-person CHW certificate program called the Reentry Specialist Certificate, offered at City College of San Francisco.

In two different studies, the TCN model has been demonstrated to reduce emergency department visits and preventable hospitalizations by half.[1] It is clear that the health plans covering these members can save money, and yet clinics operating a TCN program need to consider how they can support the salary of one or more CHWs. Some clinics are implementing CHW services without specific funding in the belief that future payment models will incorporate new staffing models and services.

The items below represent a menu of funding options for clinics and health systems to consider in covering CHW services. Some will be more applicable to Federally Qualified Health Centers (FQHCs) and others to county clinics; several have relevance for all clinic models. Most Transitions Clinic programs blend funding from two or more sources.

Health Homes Program

Authorized by the Affordable Care Act and California AB 361, the Health Homes Program for Patients with Complex Needs (HHP) is designed to serve Medi-Cal beneficiaries with multiple specified chronic health, mental health, and/or substance use disorders who frequently use health care services and may benefit from enhanced care management and coordination. As of November 2018, HHP programs are being implemented in 11 California counties, with many additional counties to follow in 2019. Clinics can consult with their counties, or view the implementation schedule (PDF).

HHP cannot reimburse for medical or social services, but is instead explicitly focused on care coordination, referrals, case management, and transitional care. HHPs are therefore an ideal funding source for the CHW role. The criteria for eligibility include multiple chronic conditions, an inpatient stay or three emergency department visits in the last year, and/or chronic homelessness. Potentially eligible members are identified by the Department of Health Care Services (DHCS) and sent to managed care plans; therefore, this source of financing is likely to cover some but not all Transitions Clinic patients. Safety-net clinics wishing to participate in Health Homes must do so by contracting with the clinics' local Medi-Cal managed care plans. Although details about how plans will compensate providers for HHP services are just emerging, it is a good time to begin negotiations, even for those counties facing later implementation.

HEALTH HOMES PROGRAM: PRO AND CON

+	It provides the TCN program with a reliable funding source and engages the health plan(s) in the model. HHP can also be used to support services for non-TCN patients if the clinic wants to include a broader target population.
−	The criteria for eligibility in HHP include high community health care use, and not all Transitions Clinic patients will meet this requirement because many were recently released from incarceration. TCN programs aim to prevent clients from using unnecessary health care services. Because health plans are HHP funders, clinics with multiple managed care contracts may find this more challenging to manage or administer. Also, CHWs working under HHP need to develop a comprehensive Health Action Plan for each patient. This practice is very consistent with the TCN model, but the volume of documentation may be challenging.

Whole Person Care

California's latest Medi-Cal waiver, Medi-Cal 2020, includes a provision for Whole Person Care (WPC) pilots. WPC pilots aim to increase integration and improve coordination for vulnerable Medi-Cal beneficiaries who are frequent users of multiple health care systems and have poor health outcomes. Pilots in 25 counties are approved, with incentive payments and contracts along with processes for care coordination across a spectrum of services and supports. Funding can also help support data sharing and data tracking for outcomes. One goal of the WPC pilots is to reduce inappropriate use of emergency and hospital care.

Under WPC, counties receive federal funding and identify target populations and project partners. One of the optional target populations is individuals with chronic conditions who were recently released from incarceration. WPC pilots can pay for care coordination and also for an array of social services.

> At least six counties, including Contra Costa, Kern, Los Angeles, and San Joaquin, are prioritizing reentry patients as part of their WPC pilots. In Los Angeles, WPC funding is supporting the hiring of 128 CHWs with histories of incarceration to provide services to high-risk patients after their release from jail and prison.

WHOLE PERSON CARE: PRO AND CON

+	WPC pilots are well-funded, and the focus on coordination, housing, and systems is a good fit for the work of CHWs serving in TCNs. Funding can support systemic improvements beyond staff costs, such as data systems.
−	WPC is not a permanent funding stream (although a waiver continuation/renewal is possible). Not all counties are participating.

Flipped Visits

In FQHCs and FQHC Look-Alikes, where Medi-Cal Prospective Payment System (PPS)[2] reimbursement is only available for face-to-face visits with licensed medical, mental health, and dental providers, there are options to help support CHW visits with Transitions Clinic clients using a warm handoff to a medical clinician.

Flipped visits are used commonly by health centers inside and outside of TCNs. For example, many health centers flip visits from health coaches or nurses to clinicians in the context of blood pressure management or diabetes care.

The model is simple. A visit is scheduled with the CHW, who conducts an intake with the patient, updates changes in health status, counsels and coaches, and documents the visit in the electronic health record or care record. Then, toward the conclusion of the visit, especially for patients who have medical needs beyond the CHW scope, the medical provider spends a brief amount of time with the patient without displacing other scheduled appointments, reviews and updates the treatment plan, and discharges the patient. This level of engagement is more than sufficient to qualify for a PPS rate. The visit is then submitted with the medical provider as the rendering provider, and the provider's signature is the one included on the progress note.

If a CHW sees 20 patients in a typical week, and only five of these are "flipped" to the medical provider, (assuming an average PPS rate of $220 and 45 work weeks per year) this strategy would generate approximately $50,000 per year in visit revenue — about the average salary for a CHW before benefits and indirect costs.

FLIPPED VISITS: PRO AND CON

+	Does not require any special contracts but instead builds on billing structures already in place. Payments can be quite substantial and cover a good portion of CHW costs. Using this system can also help shorten the amount of time medical providers spend with each patient, allowing them to see more patients and generate additional billing revenue (not included in the calculation above).
−	All staff must be trained to document appropriately in the various billing and medical records. For example, procedures are needed to adjust the appointment so it reflects the time with the licensed provider. Executives should consider how to reflect flipped visits in productivity reports and calculations. Clinicians can sometimes experience these warm handoffs as disruptive to their patient flow, unless they have lightened loads or are designated the "provider of the day," and should understand what is expected of them in advance.

Short-Doyle Mental Health (County Mental Health)

For patients who meet diagnostic criteria, Short-Doyle Medi-Cal is a funding source that covers not only mental health treatment but also intensive case management services. Providers must be certified by their local county as fully eligible Medi-Cal mental health providers and have a current contract to provide Short-Doyle (also known as county mental health) services. Patients must be enrolled with that contracted provider to receive mental health treatment services from licensed mental health clinicians in order to access Short-Doyle case management funding. Case management activities include communication, coordination, and referral; monitoring service delivery to ensure patient access to service and the service delivery system; monitoring the patient's progress; placement services; and plan development.

SHORT-DOYLE MENTAL HEALTH: PRO AND CON

+	Offers safety-net clinics with mental health service infrastructure the potential to leverage a variety of nonfederal funding sources and realignment funding. Although the program has been restrictive in the past, some counties are now expanding the range of provider types with which they contract.
−	Patients must meet medical necessity criteria, have a mental health diagnosis, and meet specific impairment and intervention criteria. Providers must be contracted by the county and bill for services provided. Matching funding is required. The program requires licensed staff and specified amounts of clinical supervision. Clinics must have the infrastructure to manage the care of patients with serious mental illness and be able to track and bill by service units.

Shared Savings with Managed Care Organizations

Because there is compelling evidence to suggest that TCN programs can reduce health care costs, some health plans or managed care organizations may be willing to help fund the salary of a CHW. They can do this in different ways: reimbursing clinics directly for CHW services using a negotiated fee schedule, supplementing the per member per month capitation rate, and/or paying for CHW salary through a grant or transfer agreement.

The Value Proposition

Reduction of ED use by Transitions Clinic program (TCP) patient-members	50%
ED visits per TCP member (average)	3.2
ED cost to health plan (average)	$1,233
3.2 visits × $1,233 =	$3,946
Per member savings to health plan of TCP	$1,973
Typical annual number of TCP patients served by CHW	50
Overall savings per CHW	$98,640
Cost of average CHW with benefits	$70,000
Net benefit	**$28,640**

SHARED SAVINGS WITH MANAGED CARE ORGANIZATIONS: PRO AND CON

+ Constructed well, this arrangement can be mutually beneficial and help forge strong commitments to the Transitions Clinic program over time. If successful, managed care organizations may want to expand this arrangement to other at-risk populations. Additional cost savings that can accrue through the TCN model, such as reduction in hospital stays, are not included in the illustration above.

– This agreement may be more challenging to negotiate if TCN clients belong to multiple managed care organizations, since the benefits will not accrue to a single payer (although it may be possible to structure agreements across multiple plans). FQHCs should be aware that revenue received from health plans under shared savings arrangements may be subject to the PPS reconciliation process, and so they may want to seek advice on how to ensure it will be protected or excluded.

Contracts and Grants

Traditionally, time-limited grants from private foundations, donors, community benefits, or government agencies provide the majority of funding for CHW services and programs. These grants are often targeted toward specific populations[3] or health conditions and typically end after three years or less.

In addition to traditional philanthropy, the current climate in California is supportive of projects like TCNs through various criminal justice reinvestment options. Santa Clara County is using some of its AB 109 realignment funding to support TCN programming, and in Los Angeles County the Office of Diversion and Reentry is using SB 678 and Proposition 47 funding to pay for CHWs in primary care settings.

CONTRACTS AND GRANTS: PRO AND CON

+ Grants can be very helpful when starting a new Transitions Clinic program because funders understand the need for start-up costs when initiating a new program and because it may allow the program to explore and establish other funding from the menu listed here.

– The lack of sustainability can disrupt continuity of care and may require a program to shift priorities midstream. Some clinics are willing to take this risk, with the belief that the move toward value-based payment over time may allow global capitation that covers CHW services.

Medi-Cal Administrative Activities

Medi-Cal Administrative Activities is a funding stream used by most California counties to pay for services such as Medi-Cal outreach, eligibility determinations, program planning, and coordinating health care access. This funding stream reimburses based on costs determined through a time study method. The program requires a nonfederal match similar to the state share for other Medi-Cal programs.

Several aspects of the CHW role in a Transitions Clinic are eligible activities under Medi-Cal Administrative Activities, including making referrals, coordinating client health care needs with other health care providers, and arranging transportation.

To use Medi-Cal Administrative Activities, agencies must either be a "local government agency" (as defined by the state) or contract with one. Community clinics and other community-based organizations can contract with county local government agencies to receive Medi-Cal Administrative Activities funding.

Alameda, Santa Cruz, San Diego, and Plumas Counties contract with community organizations for Medi-Cal Administrative Activities services; however, there are not any known TCN programs using this approach.

MEDI-CAL ADMINISTRATIVE ACTIVITIES: PRO AND CON

+	May be an attractive option for county clinics in particular, and for partners willing to explore this collaboration. Because Medi-Cal Administrative Activities is well-established, most counties have experience and expertise with administering it, and it should therefore be sustainable over time.
−	Requires participating employees to complete time surveys; these can seem burdensome to those not accustomed to this kind of documentation.

Targeted Case Management

The Medi-Cal Targeted Case Management program reimburses participating counties 50% to 90% for the federal share of the cost of providing case management services to target populations. As with Medi-Cal Administrative Activities, a nonfederal match is required. Three of the five target populations include people who are medically fragile, at risk of institutionalization, and in jeopardy of negative health or psychosocial outcomes. Most TCN patients should be eligible for targeted case management based on their health and/or incarceration status.

Targeted case management funding can be used to support case management services that assist those eligible for Medi-Cal in accessing needed medical, social, educational, and other services. Service components include needs assessment, goal setting, service planning, scheduling, crisis assistance, and periodic evaluation of service effectiveness. Targeted case management funding is based on time surveys, actual costs, and service documentation.

As with Medi-Cal Administrative Activities, agencies must either be a "local government agency" or contract with one to access targeted case management funding. Typically, the local county health agency is the local government agency and subcontracts with a community-based provider. Unlike Medi-Cal Administrative Activities, counties must first be identified as providing targeted case management in California's State Plan Amendment (SPA) or request that DHCS submit a change in the SPA to the Centers for Medicare & Medicaid Services.

Several counties contract with community organizations for targeted case management. The Alameda County Health Care Services Agency contracts with a community clinic based in Oakland for this service in its Transitions Clinic program.

Los Angeles County hires and trains CHWs using Whole Person Care funding with the long-term plan that the CHWs will meet the targeted case management work experience requirements by the end of the WPC project, at which point the county can transition CHW costs to targeted case management financing.

TARGETED CASE MANAGEMENT: PRO AND CON

+ Like Medi-Cal Administrative Activities, targeted case management is a relatively stable funding source, and one that might be especially well suited to a county TCN program. County staff typically have experience with time study documentation. Funding is based on actual costs.

− To bill for targeted case management services, CHWs must meet specified levels of education and/or work experience — a minimum of four years total — that many CHWs would not have upon hiring. Interested agencies should plan sufficient time for due diligence, relationship building, and training. Ongoing time studies are also required to claim targeted case management funding. Historically, very few FQHCs have participated in the program because of a belief that they are ineligible and the fear that the state will include the revenue in the agency's annual PPS cost-reconciliation process.

Funding for Medication-Assisted Treatment

Funding specific to medication-assisted treatment (MAT) for opioid use disorder is increasingly available through the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration, and other sources. Some FQHCs already receive this funding enhancement as part of their HRSA Section 330 base funding grants.

FUNDING FOR MAT: PRO AND CON

+ MAT and other addiction-related services are aligned with the goals of the TCN program, and CHWs are ideal team members for patients struggling with addiction. Because of this alignment, MAT funding can be one of a complementary group of Transitions Clinic funding tools. A growing body of technical assistance is emerging for clinics that want to provide effective MAT services.

− Not all clinic patients face opioid addiction, and MAT is only one component of an effective approach to reducing opioid dependence. It is also only one of the many services needed by TCN patients. Clinics considering using this source of funding should become familiar with the specific funding requirements and ensure that using this funding source will not artificially limit the scope of their Transitions Clinic CHW.

California's MAT Expansion Project will offer many funding opportunities for clinics starting or expanding MAT services, as part of its MAT Access Points project. Funding opportunities will be announced in early 2019.

About This Series

The California Health Care Foundation commissioned *How to Pay for It*, a series of short papers that focuses on reimbursement mechanisms for strategies that advance integration of behavioral health and medical care.

About Pacific Health Consulting

The Pacific Health Consulting Group provides management consulting services to public sector and community-based health care organizations. With a focus on managed care development and health care delivery service improvement in the California safety net, Pacific Health Consulting Group's clients include state and local health agencies, public hospitals, local public Medi-Cal managed care plans, community health centers, and other organizations that deliver or finance health care services. For more information, visit www.pachealth.org.

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Endnotes

1. Emily A. Wang et al., "Engaging Individuals Recently Released from Prison into Primary Care: A Randomized Trial," *American Journal of Public Health* 102, no. 9 (Sept. 2012): e22–e29, doi:10.2105%2FAJPH.2012.300894. Publication pending with data showing lowered hospitalizations and re-arrest rates.
2. "Medicaid Prospective Payment System," Natl. Assoc. of Community Health Centers, www.nachc.org. Medicaid payment rules for FQHCs differ from those for other providers because federal law has established a prospective payment system prescribing how FQHCs are to be paid for each encounter or visit. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) replaced the traditional cost-based reimbursement system for FQHCs with a new prospective payment system. This payment is a unique payment rate for each FQHC.
3. Realignment AB 109 (2011) transfers responsibility for supervising certain kinds of felony offenders and state prison parolees from state prisons and state parole agents to county jails and probation officers. Proposition 47 was a ballot initiative passed by California voters in 2014. It reduces certain drug possession felonies to misdemeanors. SB 678, the California Community Corrections Performance Incentives Act of 2009, establishes a system of performance-based funding that shares state general fund savings with county probation departments that reduce their probation failure rate. At the center of SB 678 is the use of evidence-based practices and incentive-based funding to improve public safety.